

Lab Use	Job No:
Items Rec'd:	Date Rec'd:
Treatment Plan/Quote Sent:	
Tech Initials:	Approved:
1 <sup>ST</sup> Aligners Sent:	Final Aligners Sent:

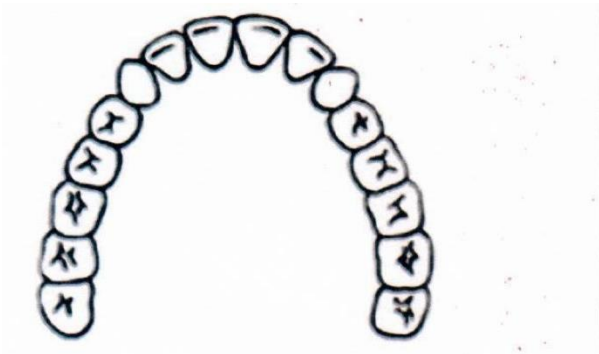

## Treatment Plan Request


Date Imps Taken:	Date Plan Required:
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Patient:	Patient No. (if any):
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Clinician:	Practice:
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Practice Address:	Tel No:
	Email: (must be provided to email treatment plans)

Upper arch teeth to be moved	Lower arch teeth to be moved
	

Additional Information:		
Interproximal Reduction IPR	Composite Attachments	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	